

# CITY OF RIVERSIDE DENTAL BENEFITS ENROLLMENT/CHANGE FORM

<b>Name of Subscriber: Last</b> <b>First</b> <b>M.I.</b> <b>Social Security No.</b>				<b>Birth Date:</b> _____ <b>Sex:</b> Male      Female <b>Marital Status (Circle One)</b> Single      Married      Divorce <b>Marriage/Divorce Date:</b> _____		<b>Indicate actions that apply:</b>	
<b>Address</b> <b>City</b> <b>State</b> <b>Zip</b>				<input type="checkbox"/> New Enrollment <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> Cobra <input type="checkbox"/> Edit Name/Address		<input type="checkbox"/> Delete Dependent <input type="checkbox"/> Add Dependent <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change Dental Office <input type="checkbox"/> Cancel Coverage	
<b>Department/Division</b> <b>Hire Date</b> <b>Work Phone</b> <b>Home Phone</b>							

<b>Choose Your Dental Plan (Select One)</b>	<b>If dependent(s) have a different address, please indicate. If you have a college age dependent this entire section must be completed.*</b>																				
<input type="checkbox"/> Deltacare PMI/DHMO Group # <u>00898-</u> _____  <input type="checkbox"/> Delta DPO Dental Group # <u>0642-</u> _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><b>Student/Dependent Name</b></td> <td style="width: 30%;"><b>Address</b></td> <td style="width: 15%;"><b>City</b></td> <td style="width: 15%;"><b>State</b></td> <td style="width: 10%;"><b>Zip</b></td> </tr> <tr> <td colspan="5" style="height: 20px;"></td> </tr> <tr> <td><b>Name of Institution</b></td> <td><b>Address</b></td> <td><b>City</b></td> <td><b>State</b></td> <td><b>Zip</b></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td><b># of Units</b></td> </tr> </table>	<b>Student/Dependent Name</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>						<b>Name of Institution</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>					<b># of Units</b>
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				<b># of Units</b>																	
For HR Use Only	<b>Do any dependents have other dental insurance? If yes, please complete:</b>  <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><b>Dependent's Name</b></td> <td style="width: 30%;"><b>Insurance Company Name</b></td> <td style="width: 20%;"><b>Policy No.</b></td> </tr> <tr> <td colspan="3" style="height: 20px;"></td> </tr> </table>	<b>Dependent's Name</b>	<b>Insurance Company Name</b>	<b>Policy No.</b>																	
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## List Eligible Person(s) to be Covered OR Person(s) to be Deleted

Relationship	Last Name	First	M.I.	Social Security No.	Birth Date	Age	Dental Office Code**	Dental Office Name and Address	Existing Patient
<input type="checkbox"/> Self									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Spouse									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No

\*Must be completed for Overage Dependent who are 19 years of age and over. \*\*Dental Office Code must be filled in for Deltacare PMI/DHMO.

### Enrollment Agreement and Payroll Deduction Authorization

I acknowledge that the above information represents my enrollment choice(s). I understand my coverage elections cannot be changed until a future benefits enrollment period. I represent that to the best of my knowledge and belief, all statements and answers made on this form are true and complete. If applicable, I authorize any insurance company, hospital, physician, or any other health care provider to release all information to all those who may have a bearing on benefits available under this plan. Adjustments may be made to increase or decrease the amounts specified for deductions by the City, provided that the method, manner and amount of such deductions are in full compliance with applicable laws and administrative rules and regulations of the City. The employee portion of the deduction will be automatically deducted pre-taxed on a biweekly basis.

I understand and agree to the terms and conditions described above.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Original/Insurance Co.

Yellow/Employer

Pink/Employee

